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EDITORIAL COMMENT

The academic year 1986-87 has whistled by already for most. For those in their training and those that are now practicing, several issues have arisen that will affect the way they practice in the coming years. The Human Immunodeficiency Virus (HIV) is now appearing in groups other than select "high risk" individuals. The AIDS virus is receiving lots of literature in newspapers, national medical journals such as CMAJ and JAMA, and specialty journals. High false positives in tested groups other than those that are "high risk" make it somewhat debatable to begin using current methods in screening (other than for blood donations) to identify HIV antibody positive persons. Recent studies out of Vancouver and other locations suggest a time factor for a person to seroconvert from negative to positive for HIV antibody. It may be soon that screening programs in community hospitals and doctors offices begin using tests that offer exquisite precision in this regard.

Over the last few years, south of our border, doctors have had to deal with an increasingly litiginous population. In Canada malpractice insurance is rising for almost all areas of interest in medicine with obstetricians, orthopedists, and neurosurgeons leading the way in annual premiums. Family doctors are getting out of the business of delivering babies perhaps because of the present stable birth rate; FMD obstetrical care that includes delivery doesn't offset insurance costs in many instances. Our Ontario government has announced that it is planning to hold various professional discipline hearings in public, physicians included. Medical practitioners will be changing their "medical habits" in the near future if they haven't started now; society is demanding womb to grave care that is not only first rate, but available to be addressed on an individual basis in a public forum. The cornerstone article of this issue is the text of a speech given by a prominent London lawyer this year. It is long, detailed, and should be of interest to physicians at any stage of training or practice. It addresses the legal aspects of medicine using "cases" as examples, offering suggestions to physicians.

Other articles in this issue include a comment by a first year medical student after finishing his year, an article by the president of Hippocratic Council summarizing committee work, and there is a FYI on internship trends over the last 2 years at Western. As with each issue, original medical cartoons by Western medical students are sprinkled about. An interestingly constructed cover graces our first page.

The 1986-87 series of The University of Western Ontario Medical Journal was a challenge and a pleasure. Thanks certainly go to all those who contributed articles. On behalf of Dave Creery the co-editor this year I would like to thank the Dean of Medicine and his office (underwriting 50% of our costs); Hippocratic Council and our advertising sponsors were equally responsible for picking up the rest of the tab. Thanks a lot!

Bob Turliuk
Meds '88

HIPPOCRATIC COUNCIL INFORMATION

One of the major roles of Hippocratic Council is to act as representatives of the students on various committees. The President of the Council is a member of Faculty Council, Executive of Faculty Council and the Steering Committee for Curricular Reform. Class Presidents are members of UMEC while Vice President Academic is a member of UMEC and CEC. From these various committees Hippocratic Council would like to provide to you, the students, information about changes or proposed changes that will affect the Faculty of Medicine at Western.

Changes for the admission procedures have been approved by University Senate. Academic results will continue to be the major determinant for admission but the interview score and candidate's statement score will also be used in the overall assessment. As well, candidates will receive credit for prior degrees. In an effort to standardize interviews, interviewers will attend a seminar in which interviewing techniques will be reviewed. Videotapes of staged interviews will be used for instruction. At the present time, there are no changes proposed regarding academic requirements.

A proposal regarding 'course weighting' has been approved by Faculty Council and must now be approved by Senate. At the present time all courses are equal weight regardless of the number of hours. With the new proposal a course will be assigned a weight according to the number of hours that a particular course is scheduled in the curriculum. A weighted overall average of 60% will be required for the privileges of supplemental exams. The courses will be weighted as follows: less than 60 hours (Biophysics, Therapeutics, Genetics) as a ½ weight; 61-160 hours (the remainder of the courses) as 1 weight; 161-261 hours (Clinical Methods, Anatomy) as 2 weight; and 400 hours (ICC) as 4 weights.

At the present time, the Steering Committee for Curricular Reform is meeting regularly to discuss possible changes to the curriculum. Various subcommittees have been considering issues involving Admissions, Faculty Development, Student Evaluation etc. The Committee has been discussing whether to implement a problem based curriculum and in what form. Plans include a report to be submitted to Faculty Council by the autumn.

As well, UMEC has formed a committee of students and faculty representatives regarding 'flagging' students with unsatisfactory performance in clinical years. Faculty would like access to information on 'weak' students in advance of starting their next rotation. At the present time release of such information is against university policy. The intent is to allow for remediation of weakness but some feel that the information may bias a student's evaluation.

This provides a summary of the major issues being discussed within the Faculty of Medicine at the present time. Since they affect you and future students your comments and opinions should be forwarded to Faculty Members or members of Hippocratic Council.

Diane Whitney - Meds '88
President of Hippocratic Council

The following is the text of a speech given to the Medical Legal Society of Ottawa Carleton, March 28, 1987

by Earl A. Cherniak Q.C. *(printed with permission)*

Reflections on the Law of Informed Consent

While I am pleased to be invited here to talk about the physicians' duty to obtain informed consent, I am afraid that I am a poor substitute for Ellen Picard, now Madam Justice Picard, who actually wrote a book on the subject. I sometimes feel that when someone like me, who sometimes takes cases against doctors, gets invited to speak at gatherings such as this that I am the Daniel to be thrown to the lions, and perhaps should have a bull's eye painted on my chest.

While it is true that I do, on occasion, sue doctors, in my defence I often defend hospitals and indeed some of my best friends are doctors. I never go on a canoe trip in the wilds without one. Further in my defence, I also sue lawyers. It is a great deal easier to win a case against a lawyer, since they usually leave a good paper trail, and the Judge cannot be bamboozled or dazzled by a grey-haired, smooth-talking, department chief or full professor as sometimes happens in medical negligence cases where the Judge has no personal expertise.

I have said many times before that no lawyer I know (a) likes suing professionals of any kind, especially doctors, and (b) can make a living doing so exclusively. This is especially so in the case of medical negligence actions, since the good ones are hard to find and one has to kiss a good many frogs before finding the fairy princess.

When I went back to my home town, Windsor, recently, a doctor friend of mine whom I grew up with told me that if I had listened to him when we were starting out in university, I too would now be a doctor.

"What's wrong with being a lawyer?", I asked him. "I don't say all lawyers are greedy crooks", he said, "but even you will have to admit that your profession does not make angels of men and women".

"You are right", I had to admit. "You doctors have the better of us there."

When I was growing up, I had the classic family doctor to look after me. He lived around the corner, had grey hair, a black bag and he made house calls. He smelled antiseptic and I thought he was the next thing to God. He probably thought so too. When I went to university, I lived in a fraternity house with a great many future doctors. I got a rude awakening. Some of them are now famous. It boggles my mind.

I was asked today to direct most of what I say to the medical part of the audience. Lawyers, of course, are presumed to know the law!

You will be happy to know that of all the legal pitfalls that can confront a doctor, the law of informed consent should be the least troubling. No reasonably intelligent doctor today should ever be found liable for failing to inform a patient properly if he or she used a modicum of common intelligence and common sense, and, above all, if he or she treats the patient and the patient's family like real people instead of OHIP numbers, **and** if a reasonable job of record keeping is done.

Indeed, the cases of liability where the only allegation against the doctor is that he or she failed to properly inform the patient, but otherwise made the diagnosis and prescribed and carried out treatment without negligence are extremely rare. The reasons for this being so will appear throughout the course of my remarks, but it would have to be a very serious and clear case before a lawyer would take on an action in those circumstances, where informed consent was the only arrow in the quiver.

Notwithstanding what I just said, an allegation about informed consent is virtually always made by careful lawyers in the pleadings in medical negligence cases, if for no other reason so that appropriate questions can be asked on the examination of discovery of the doctor as to the discussions that he had with the patient and, in appropriate cases, with his family. Even in those cases where there would be no successful action for failure to give proper advice, the completeness of the advice given, or the lack of it, can often affect or **infect** the atmosphere surrounding the diagnosis and treatment, and could make a difference in a close case as to the ultimate result on the negligence issue.

What is most important to keep in mind is that, while the obligation to inform the patient is an absolute one, it is unnecessary to over-react by giving every patient a lengthy harangue of every possible general or specific risk of the treatment involved, and either frighten or confuse the patient in so doing. No judgment of the courts in this Country requires any such thing. The standard imposed by the courts, in my view, is not a particularly onerous one, but rather one that can be reasonably met by doctors and one that will fairly and reasonably inform patients if it is adhered to.

I am not going to give you a long dissertation on the law of informed consent because others have done it better. There are some excellent reference works that do so more completely than I can, among them Ellen Picard's book on medical negligence[1], and, in particular, an excellent article in the Advocates' Quarterly by Don Ferguson of Borden & Elliot called "Informed Consent to Medical Treatment"[2]. I have drawn in part on these works for my remarks.

I will give you are some general guidelines and deal with some specific examples of cases that may help both doctors and lawyers make informed judgments as to how to approach these problems.

As a preface, there are two general principles, not legal ones, that I would stress above all others. If a doctor follows these principles, the chances of he or she getting into trouble on this issue are less than the risks of dying under general anaesthetic.

First of all, patients should be treated as people and not, as I said, as cases or OHIP numbers. They are to be treated as intelligent laymen. While they may be the doctor's 13th patient that day and 419th patient to undergo the particular procedure, the doctor must always remember that it is the patient's only case and the patient is at least as interested in the procedure or disease as the doctor was when he or she first learned about it and a good deal more personally concerned. In addition, he or she will have every reason to remember the circumstances and the conversations surrounding it much better than the doctor, or say so.

Secondly, when in doubt, apply common sense; the objective test. What would I, **if I were that patient**, want to know about the issue? This second dictum requires that the doctor knows enough about the patient to put himself or herself in the patient's shoes. That sometimes takes some judicious questioning.

If there is one single thing that drives unhappy patients into the offices of a lawyer more than any other it is the unexpected result combined with the failure of the doctor to have disclosed the possibility of that result before the procedure, and combined again with a failure to frankly and fully explain to the patient or family afterwards what happened and why. When patients can't find out, they become clients. Many of my clients simply have no idea what happened and are more interested initially in finding out what did happen than having any great desire to sue at that point. When they don't know, they suspect the worst. The problem for doctors in that situation is that the lawyer who accepts that retainer has an obligation to find out not only what happened, but whether the misadventure amounted to negligence. The fact that the doctor made no such disclosure either before or after the event may have no legal significance, because the patient may well have been found objectively to have required the treatment irrespective of whether the proper information was given, but the investigation by the lawyer may show some negligent misadventure that produced the result. The "cover-up" syndrome has more than political ramifications.

I am satisfied that many of the cases that I have had which produced the largest judgments against doctors never would have seen the light of day had the families been provided with a frank explanation by the doctor of what happened. In light of what I was able to do for some of these unfortunate people, that might not have been the best result for them, but I simply state it as a matter of fact, in my experience, for your consideration.

There is no legal risk whatever in pre-operative disclosure for tge doctor. Indeed as we will see, it is required. There may be some risk in post-operative disclosure, but whether there is or not, it always seems to me that a

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doctor has an ethical obligation to explain a poor result to a patient, without of course any admission of liability. In **Stamos** v. **Davies**[3], Mr. Justice Krever held that there was a legal obligation, and I believe that they fulfill it. I conceive it my duty, for instance, if I miss a limitation date, to advise the client that this happened and refer the client and the file to another lawyer.

Let's briefly review the law.

1. Emergency - in a true emergency where consent cannot be given, it is dispensed with.
2. Every patient old enough to know the difference has a right to determine what, if anything, should be done with his or her body.
3. A doctor who treats a patient without the consent of the patient or goes beyond the terms of the consent given, is acting illegally, perhaps even criminally.
4. Even when consent is given, a doctor will be acting illegally if he or she obtains the consent without making adequte disclosure to the patient beforehand. This illegality may or may not have civil consequences.
5. These rules apply to all medical treatment, given by all health professionals—not just doctors—and apply equally to surgery or non-invasive medical treatment or therapy.

I will deal primarily with the last two of these principles in this address. The other principles involve no consent at all, the assault or battery cases. They are usually much more identifiable and are happily rare. These cases are dealt with in detail in Ellen Picard's text to which I have referred you.

There may, of course be some grey area of overlap between the two types of cases. The effect of some kinds of nondisclosure may be such that there is no consent at all. This is an area that will require some further judicial review when the right case comes along. The difference is important because there is absolute liability for an assault, and the causation issue that I will discuss soon would not be a potential defence.

No discussion of informed consent can be dealt with in Canada without reference to the two cases decided in 1980 by the Supreme Court of Canada: *Reibl* v. *Hughes*[4] and *Hopp* v. *Lepp*[5].

In *Reibl*, the Plaintiff was a 44-year old labourer suffering from headaches plus hypertension, and the cause was unknown. He was referred to a neuro-surgeon who discovered a buildup of plaque in his left carotid artery significantly narrowing it. This condition was, in fact, unrelated to the hypertension and the headaches, and was not at the moment causing any detectable neurological dysfunction, but it was the view, reasonably held by the doctor, that it should be remedied surgically because it subjected the patient to a 10% risk of stroke each year. The remedial operation subjected the patient to a significant risk of death or stroke in the area of 14%. The Plaintiff agreed to the operation on the basis of a recommendation simply that he should have it. Although the operation was done non-negligently, the Plaintiff suffered a severe stroke and was unable to work. Every expert agreed that it was reasonable to do the operation, given this man's condition. He was not given any advice with respect to the specific risks of the surgery. He was told no more than that he needed the operation or it would be better to have it than not. He thought that the operation was related to his headaches and hypertension in some way. The surgeon did not know that it was important to the Plaintiff that, if he was able to work for one and one-half years more, he would be pensionable, which would have provided significant protection for his family.

In *Hopp*, the Plaintiff, a 66-year old man who lived in Lethbridge, Alberta needed an operation for a herniated disc. He consulted a local orthopaedic surgeon, who advised him that he needed the operation and, when asked, said that he was qualified to do so and that the operation could be done as well in Lethbridge as in Calgary. The operation was performed, the result was poor and a further operation needed to be done in Calgary and this lawsuit resulted. There was no negligence in the carrying out of the operation. In fact, it turned out that the Lethbridge doctor had never actually done one of these operations while practicing as a surgeon, although he had done many of them as a resident. This was unknown to the Plaintiff. As well, given the complications that actually occurred, it would have been easier to treat them in Calgary.

Each case had a stormy course through the lower courts. In *Reibl*, the Plaintiff was successful at trial, lost in the Court of Appeal and was ultimately successful in the Supreme Court of Canada. In *Hopp*, the reverse occurred; the Plaintiff lost at trial, was successful in the Alberta Court of Appeal, and was unsuccessful in the Supreme Court of Canada.

In *Reibl*, the most significant fact was the patient's own situation. The court could say that not only would he not have had that operation if he knew the facts necessary in order to enable him to make the decision, but also that it would have been objectively reasonable for him to attempt to continue to work to his pensionable age.

In *Hopp*, the real complaint was that the patient was not told that it was the doctor's first operation, which the court held to be irrelevant to the question of informed consent, so long as the doctor was otherwise qualified, absent specific questions on that issue.

In both those cases, the Supreme Court of Canada took the opportunity to discuss the law with relation to informed consent and largely settled the applicable principles for Canada.

The Ontario Court of Appeal in 1981 in *Videto* v. *Kennedy*[6] set out a summary of those principles in a convenient way.

1. The question of whether a risk is material and whether there has been a breach of duty of disclosure are **not** to be determined solely by the professional standards of the medical profession at the time. The professional standards are a factor to be considered.
2. The duty of disclosure also embraces what the surgeon knows or should know that the patient deems relevant to the patient's decision whether or not to undergo the operation. If the patient asks specific questions about the operation, then the patient is entitled to be given reasonable answers to such questions. In addition to expert medical evidence, other evidence, including evidence from the patient or from members of the patient's family is to be considered. In *Reibl* v. *Hughes*, Laskin, C.J.C. stated[7]:

   > "The patient may have expressed certain concerns to the doctor and the latter is obliged to meet them in a reasonable way. What the doctor knows or should know that the particular patient deems relevant to a decision whether to undergo prescribed treatment goes equally to his duty of disclosure as do the material risks recognized as a matter of required medical knowledge."

3. A risk which is a mere possibility ordinarily does not have to be disclosed, but if its occurence may result in serious consequences, such as paralysis or even death, then it should be treated as a material risk and should be disclosed.
4. The patient is entitled to be given an explanation as to the nature of the operation and its gravity.
5. Subject to the above requirements, the dangers inherent in any operation such as the dangers of the anaesthetic, or the risks of infection, do not have to be disclosed.
6. The scope of the duty of disclosure and whether it has been breached must be decided in relation to the circumstances of each case.
7. The emotional condition of the patient and the patient's apprehension and reluctance to undergo the operation may in certain cases justify the surgeon in withholding or generalizing information as to which he would otherwise be required to be more specific.
8. The question of whether a particular risk is a material risk is a matter for the trier of fact. It is also for the trier of fact to determine whether there has been a breach of the duty of disclosure.

On the facts in *Videto*, the doctor was held not liable for failing to disclose to a patient who was having a sterilization the risk of a bowel perforation, the subsequent peritonitis that would follow it and the laparotomy with the resulting scar that would be necessary if that occurred, where the doctor had no idea and no reason to know that the scar from the laparotomy would be of particular unusual concern to this patient. Objectively, so the court held, a reasonable patient would have had the operation anyway even if she had known of the risk of this possible complication. The trial Judge had found that subjectively she would not have had it because of her own particular concerns which were unknown and which could not have reasonably been known to the surgeon. The Court of Appeal reversed, applying the reasoning in *Reibl* and *Hopp* which had been decided after the trial.

Bx way of example, it might be germane to refer to two other cases in which some of the participants here have been involved (fortunately, as lawyers and Judges, not as parties).

Zamparo v. *Brisson*[8] was a case where an otolaryngologist was referred a patient by a general practitioner. The patient had headaches and the otolaryngologist during his examination noted a partial one-sided hearing loss which was previously unknown to this 55-year old widowed patient and which did not bother or affect her in any way. He recommended and

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ultimately performed a stapedectomy and during its course, he damaged an anomalous facial nerve causing partial paralysis. The surgery itself was admittedly done non-negligently, but there was found to be negligence in the post-operative treatment and there was found to be a failure to discuss fully with the patient the risks and adviseability of the procedure, given especially the elective and essentially cosmetic nature of it. Both the specialists called for the Plaintiff and the Defendant indicated that they would never have recommended this surgery for this patient. The Plaintiff's expert indicated that he would have had strong words for any resident of his who suggested it. He indicated that it was the duty of the doctor to give such an opinion to the patient, who could then make up his or her own mind based on such advice.

The trial Judge found liability both on the issue of the post-operative care and the failure to give appropriate advice. The Court of Appeal split on the issue. All members upheld the judgment on the post-operative care issue. The majority found that the doctor was not negligent by leaving up to the Plaintiff, without the surgeon's opinion, as to whether to have the surgery or not. The Plaintiff had in fact asked her general practitioner what to do, and the general practitioner had said if the surgeon recommended it, go ahead. Madam Justice Wilson in the Court of Appeal said that there was no duty to advise against the operation, and the specialist could simply remain silent on the issue. Mr. Justice Zuber, in dissent, disagreed. He referred to the evidence of the plaintiff's expert that I have adverted to, and said there was a responsibility on the surgeon to give such advice. He agreed with the trial Judge that, had the plaintiff been given this advice, she would as a reasonable person, have decided against the operation. He characterised the issue as being whether there was a duty on a surgeon in such a case as this to give the patient his assessment as to the real benefit of the surgery and whether such benefit outweighed the risks involved and his recommendation based on his assessment (lawyers of course do this all the time). Mr. Justice Zuber noted that both experts supported such a duty, but the issue was one of law and not based simple on what the surgeons would do. As a matter of law, he found that a surgeon has a duty to sufficiently inform the patient to enable her to make a choice whether to submit to the operation, and that such duty demands advice as to whether the surgery should be done, and whether it will produce a benefit which will outweigh the risks.

In *Ferguson* v. *Hamilton Civic Hosptials et al*[9], Mr. Justice Krever, then in the trial division, was dealing with a case where a 58-year old plaintiff became quadriplegic following a bilateral carotid angiography. The trial Judge found that no informed consent to this procedure was given, but in the ultimate result it made no difference, since there was no causal connection between the breach and the result, because in the circumstances, even if the correct disclosure had been made, a reasonable man in the position of the plaintiff would have gone ahead with the procedure.

Mr. Justice Krever found that the Plaintiff should have been informed by one or other of the attending doctors of the nature of the angiogram and its attendant risks. In that case, the risk of death from an angiogram was .5% and a stroke 2%. These were significant given their severity, and should have been disclosed to the patient along with the risks of the alternatives open to him, including the risk of doing nothing. It was not enough to mention the possibility of death and not the possibility of stroke, on the basis that a patient might well be willing to run a small risk of death, but not a greater risk of stroke. In addition, the discussion of risks he found should not take place just before the operation when the patient is affected by pre-operative or other drugs. He said that the patient needs time, and a proper environment to give full consideration to his position. After so finding, he dealt extensively with the issue of causation, which is worth a short discussion. He analyzed the plaintiff's own evidence that he would not have consented and compared it with the objective evidence of his condition. He found that there was no economic reason for this plaintiff not to consent, and he relied also on the risks of future stroke if nothing was done, the angiogram should be performed. He found that a person in the plaintiff's position given the alternatives would have opted for the procedure. His Lordship said:

> "I cannot avoid the conclusion that any reasonable patient in Mr. Ferguson's position and whose livelihood as a truck driver would have been threatened by episodes of loss of vision, on weighing the risks of the procedure had he been properly informed of them against the more serious risks of doing nothing or resorting to alternative therapy without confirmation of the provisional diagnosis of carotid stenosis, would have opted for the procedure[10]."

You can see from the result in *Ferguson* that it is still possible for an aloof or insensitive doctor to rely on the proposition that he or she knows what is best for the patient without fully discussing it and knowing enough about the patient to have a meaningful discussion with him. However, such a dinosaur had better be right.

What should be disclosed? I can do no better than refer extensively to the excellent Article by Mr. Ferguson that I mentioned earlier. What follows is a summary of what he said.

As already discussed, the new general rule is that a doctor must disclose all the information that a reasonable person in the patient's circumstances would want to know before choosing to accept or reject the treatment.

The decided cases have specified a number of kinds of information which should be disclosed. However, the kinds of information which must be disclosed will depend on the facts of each case. We must recognize that the list is not complete and may indeed not apply in all cases. The disclosure entailed in prescribing cough medicine will obviously be different from that preceding heart surgery. Various cases have indicated that the following should be disclosed:

1) a description of the treatment;
2) the benefits of the treatment and the likelihood of achieving the benefits;
3) whether the treatment is necessary or elective;
4) if the treatment is necessary, whether it is urgent or can be postponed;
5) the risks during the treatment and the likelihood of each materializing;
6) the risks related to the treatment (e.g., after the treatment) and the likelihood of each materializing;
7) alternative available treatments and the related risks;
8) the consequences (including risks) of refusing the treatment;
9) the inevitable adverse consequences of receiving the treatment;
10) the recommendation of the doctor as to whether or not treatment should be given; and
11) any information which the patient specifically requests.

So far as risks are concerned, it is not **every** risk which must be disclosed. It is only those which are "material" or which are "special or unusual". The meaning of these terms is not at all clear but would include the following risks:

1) those which frequently materialize;
2) those which have serious consequences when they do materialize (e.g. stroke or death);
3) those which would likely affect the decision of the particular patient to accept or reject treatment.

As indicated by the third category, the courts sometimes become trapped in circular reasoning. It may be that the semantics can be ignored and the issue of what risks should be disclosed can really only be answered by applying the basic test: would a reasonable person in the patient's position want to know about it?

With respect to any risk which must be disclosed, the doctor should disclose the frequency of the risk materializing and the severity of the consequences if it does.

There are a few other matters that are worth discussing in the limited time that we have.

1. Problems of proof

The law is now pretty well settled. What causes the difficulty in most cases are questions of fact—who said what and when. My experience is that the memory of both patients and doctors tends to become very selective in favour of the position they are advancing, a natural human tendency, often done quite honestly, sometimes unfortunately not. People often hear what they want to hear and block out the rest, and similarly remember only what they want to. Studies have been done, one of which is outlined in a most interesting way in Mr. Ferguson's paper, that indicate that patients who have in fact been told of risks and complications do not in fact remember them, or remember what they had been told quite inaccurately. In the particular study, the average recall of controlled, complete advice, even after prompting of these patients (none of whom had an adverse result), was only 42%, the topic most poorly recalled was potential complications. Where a patient failed to recall a particular topic, he usually denied that it had ever been discussed at all, and two of the 20 patients involved in the study complained that the interview had been very brief and uninformative although in the actual study, it had lasted 30 minutes. It appeared that the patients who were most self-assured and appeared to be the best witnesses, were in fact the least accurate in their recollections. One can only speculate as does Mr. Ferguson as to whether a similar study done on the recollections of doctors would be any better.

There is, therefore, no substitute as far as the doctor is concerned of an

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accurate record of the fact of the conversation, and at the very least the topic headings discussed, perhaps with some elaboration. To be most useful, this recollection should be contemporaneous, written or dictated. Absent such contemporaneous documentation, doctors run a real risk that the patient's version will be accepted. After all, in many cases, the doctor has to rely on what he or she usually does, whereas the patient is speaking of the only experience he or she has ever had.

Parenthetically, I should add that record keeping does not necessarily include the kind of record made by a doctor who was a defendant in a medical negligence case that I just finished in another province. He entered in his patient record just after the untoward event occurred, "there will be trouble over this one". (However helpful this kind of notation may be to plaintiff's counsel.)

Some advice that has been given to doctors in these circumstances includes:

a) for doing standard operations, give the patient a written explanation of the procedure and the risks;
b) dictate a note on the office or hospital chart;
c) ask the patient to repeat the communication;
d) communicate with both the patient and his family;
e) have a standard consent form signed;
f) have a family member witness the consent;
g) keep a brief check list of standard communications for a particular procedure and check it off and stapling it to the patient's chart;
h) use simple language; and
i) make the disclosure at the earliest possible date, so as to give the patient lots of time to consider.

These of course are, to some extent, counsels of perfection but they are none the less useful.

These are some of the general principles.

What about some of the specific everyday problems that arise?

What about risks that are not special or material?

These include, I think, those risks common to any operation, such as the very small risk of death in any general anaesthetic as opposed to a particular or statistical risk that applies to a particular procedure, and includes risks which will not likely affect the person's well being or economic life. They include such things as the general risk of infection in any hospital and the like, unless for instance there was a specific risk of complication from infection unknown to accompany a particular kind of procedure.

What about printed consent forms? I have never yet seen a case that was decided on the basis of a printed consent form or on the basis of a consent signed at a hospital, even though they are invariably in the hospital, but it is the proof of information given, not the signing of the consent form that is important.

What about the case where the doctor thinks it would be against the patient's interest to tell them of the risks, since it might scare them away or upset them?

My own personal experience tells me that sometimes the cruelest thing that one can do is to keep information away from people on the theory that we know better than they what they should know. When they find out later, they tend to be more unforgiving and upset about not being told than they ever would have been had they had the information, especially if things go wrong. Having said that, there may well be some cases where this consideration is present. It will certainly make a difference whether you are dealing with a case where the procedure is necessary to the well being of the patient or purely elective in the cosmetic sense. On this issue, I refer you to what the Supreme Court of Canada said in *Hopp* v. *Lepp*[11]:

> "...when the question is whether the surgeon has a duty to warn the patient
> ...it may be relevant to that duty whether the patient is in a condition to make a choice.
> I am far from persuaded that the surgeon should decide on his own not to warn of the probable risk of hearing or other impairment if the course of treatment contemplated is administered. A surgeon is better advised to give the warning, which may be coupled with a warning of the likely consequence if the treatment is rejected. The patient may wish to ask for a second opinion, whatever be the eminence of his attending physician. It should not be for that physician to decide that the patient will be unable to make a choice and, in consequence, omit to warn him of risks."

What about emergencies and semi-emergencies?

Clearly, the court will consider the circumstances of each case. In the true emergency, the operation can be done without any consent. One should keep in mind however the difficulty of properly informing a sedated patient and one under stress without time to think about it and consult his or her family. If that kind of speed is indeed necessary, and the circumstances are not the best, there must be an added duty on the doctor to carefully document what happened and the reasons for the urgency. The court will be very reluctant to second guess a doctor who acted honestly in a true emergency.

Can a specialist rely on the family doctor to give the necessary information, or vice versa? This is a difficult question. The best answer is that clearly the treating doctor has the prime responsibility and cannot delegate it. However, if the information is in fact given by a resident or an intern or the family doctor, then that will be sufficient, however dangerous it might be to rely on others.

CONCLUSION

I come back to what I said at the start of this talk: The obligation of disclosure is clear. The issue in most cases comes down to common sense and to practical questions of proof. If a doctor treats his or her patients as people and not numbers, takes them into his confidence, discusses their condition and the procedures, the general and specific risks after learning enough about the patient to know what they probably should know, answers their further or other questions, gives his or her opinions fairly and frankly, makes a reasonable note of what he or she did and why, the chances of being second-guessed by a court are virtually nil. Even better from the doctor's point of view a doctor who adopts this common sense, modern approach stands a very good chance, even in the case of misadventure, of never being faced with the consequences of it. That will require lawyers such as myself to look for other kinds of cases to fill their docket. I, for one, will not be sorry.

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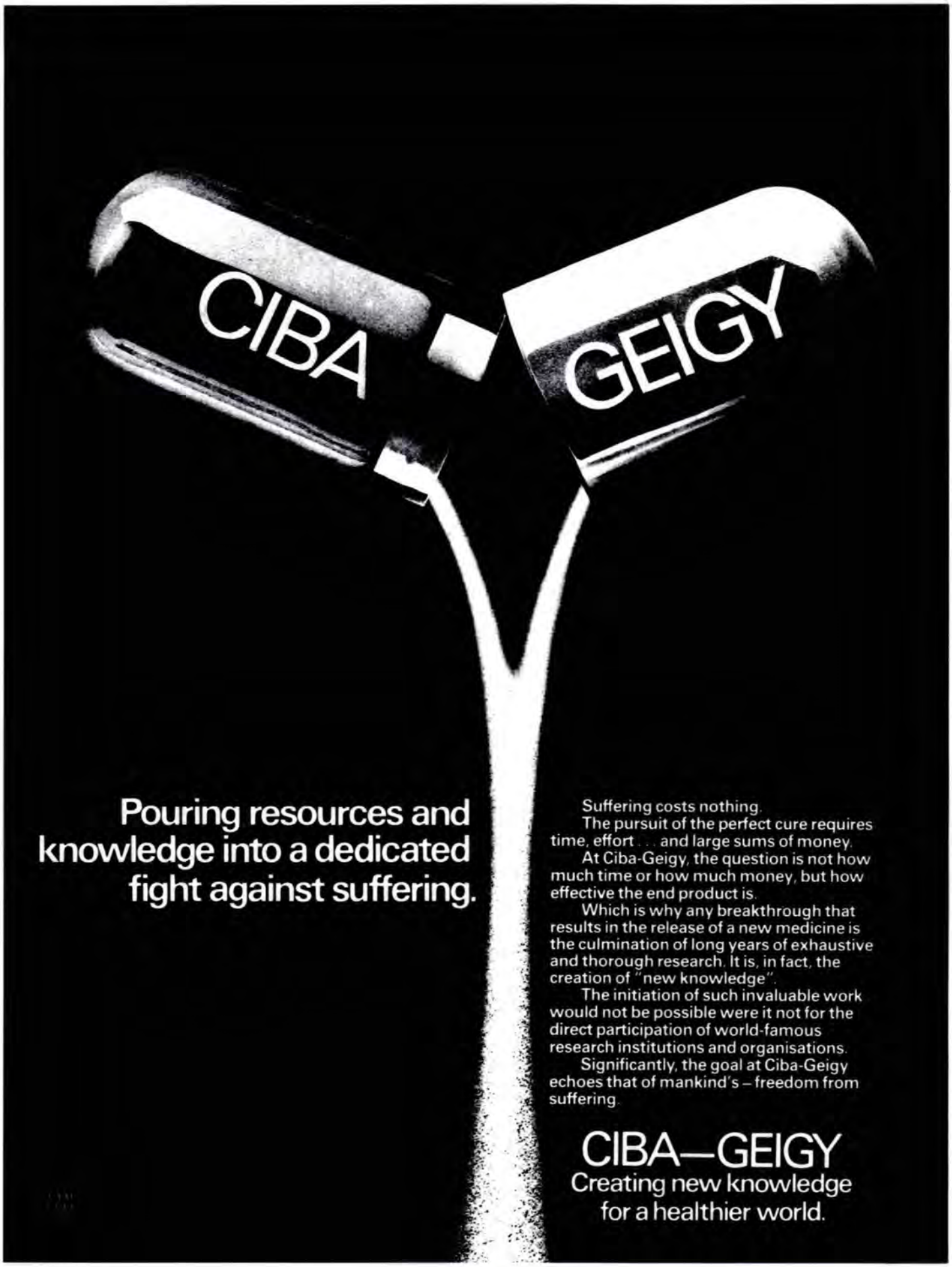

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MEDS 90: The Year in Review

Finally, the first year of our medical education has been completed. Worries are over as we lie contently in the sun daydreaming, reminiscing and congratulating ourselves about the one quarter that we have completed. But one quarter of what? We have only touched the waters of this expansive field and no student nor doctor can claim to have finished his education. However, such morbid futuristic thoughts do not have their place during the summer holidays. Instead, let's review the hills and valleys of yesteryear.

Pre-med: In one enormous sea of applicants each person was his own ship. Still, some ships came in convoys but others sailed forward alone, to cross a gap as large as the Atlantic Ocean, full of storms and hurricanes to sweep away and waylay the unwary med-hopeful. In the end, we were all carried by the same friendly wave to be beached on the shore of a new land...Medical School.

Medical School: After so many years of being at sea, standing on solid ground was an exhilirating experience carried to even greater heights during the orientation week. Here was a new group of explorers, standing at the peak of the Appalachians, full of confidence and ready to forge forward. We all had been assured that Meds was well, a walk in the park. The Dean's barbeque, Fanshawe picnic, class parties, baseball, volleyball and soccer intramurals were some of the abundant highs.

Suddenly, a river appeared in front of us, one that had to be forded, the first couple of exams. It was a river equivalent to the St. Lawrence River, perhaps the most dangerous river of the journey. It was something that could sweep one back into the Atlantic Ocean to be possibly lost forever. A few of us lost their footing in the crossing but none of us drowned. Instead, each was saved and each explorer was helped by a fellow explorer.

The Canadian Shield was next, full of small dips and gorges (exams) but also hills and peaks (Tachycardias' McBreath production, Pubs, parties, Christmas and Spring breaks, ski and Ottawa trips, Meds formal and relay, Grand Bend, indoor soccer, broomball, volleyball and hockey).

Then, the flat Great Plains were reached, the preparation for the last hurdle of final exams. At the time, it seemed like a long suffering march through the same scenery, and yet it was different. We could all see that the end of the trail was near.

Suddenly it was over. The feeling of being on top of the Rockies and seeing what we came through and what lay ahead was great. Then we tumbled down the side of the Rockies to land with a big splash (the class party) into the summer holidays. Each explorer received a well deserved rest, a swim in the crisp, clean waters of the Pacific, away from the land of Medicine. Some will research and study the land further. Others will explore totally unrelated worlds. Some will be "ambassadors of compassion" (Premier Peterson, Re: Haiti) and yet others will just lie on the beach.

We have conquered the first new land of Medical School, but what lies ahead? New worlds and new places, another adventure on its own and another tale to be told.

Postscript: I would like to thank V.P. Rich Cornell, Treasurer Atul Kapur, Social Conveners Carolyn Caplin and Jill Hickling, Sports Reps Steve Hoey and Christine Roberts, Tachy Organizers Ed Sabga and Akira Sugimoto and all the representatives for courses and committees. Most of all, I would like to thank all of the explorers of the class for their work, unity and unselfishness in our common goal.

Dorian K.C. Lo, Meds 90
Retiring Class President

(Editor's Note: I tempted to use editorial licence in several places, but it just seemed to "flow".)

ACADEMIC AWARDS 1985-86

The following are awards that were won in the academic year 1985-86. Apologies for tardiness, but due to the volume of material received for publication this year, this summary was deferred until this issue.

THE UNIVERSITY OF WESTERN ONTARIO
FACULTY OF MEDICINE

SCHOLARSHIPS AND PRIZES - 1985/86

Entrance Scholarships

The London Academy of Medicine Memorial Scholarship
- David Robert Ohrling

The Helen Artfield White Scholarship
- Andrew Sak Yu Lee

Other Scholarships

The Faculty Association Scholarship
- Goran Eryavec

The P.J. Leahy Award
- Hema Patel

FIRST YEAR

Verda Taylor Vincent Scholarships
First - Marc Pope
Second (tied) - John David Kay
Second (tied) - Stewart Wayne Kribs

The Alan C. Burton Memorial Prize in Biophysics
-John David Kay

J.B. Campbell Memorial Scholarship in Physiology
- Mario Fernandez Sandejas

Hippocratic Council Anatomy Award
- Ronald Richard Komar

C.V. Mosby Company Scholarship Awards
Biochemistry - Marc Pope
Histology - Marc Pope

Lange Awards
- Daniel Noah Frederick Goodman
- Janette Elaine White

Dr. Marvin L. Kwitko Scholarshipin Anatomy
- Marc Pope

SECOND YEAR

PAIRO Trust Fund Award
- Tracey Ann Therese Mariarity

R.S. Kaplan Scholarship
- Donna Anne Cooper - First (tied)
- Gregory John Garvin - First (tied)

Martin and Mary LeBoldus Award
- Julie Katherine Allen

Alexander Hotson Memorial Scholarship
- Jack Ven Tu

The Upjohn Achievement Award in Pharmacology
- David Richard McMillan

The Merck, Sharp and Dohme Awards in Therapuetics
- Lori Ella Bruce - First
- Mark David MacLeod - Second
- Janet Elizabeth McKay - Third

The Ciba Prize
- David Richard McMillan

The M.D.S. Health Group Ltd. Pathology Prize
- Charles Lester Burkholder

The Dean Russell Prizes in Neurosciences
- Frederick Edward Arthur
- Wayne Tadashi Tonogai

The Lange Awards
- Donna Anne Cooper
- Gregory John Garvin

The Collins Memorial Prize in Geriatric Medicine
- Jeffrey Luke McKinnon

The Class of '43B Award
- Jack Ven Tu

C.V. Mosby Company Scholarship Award - Microbiology
- Wayne Grant Hanson

THIRD YEAR

The Benjamin Weidenbaum and Cecelia Rotstein Scholarship
- Clare Colleen Romano
- Gary John Redekop

The Martin and Mary LeBoldus Award
- Janet Alison Lawrence

The Charles E. Frosst Medical Scholarship
- Lee Ann Marie Wills

The Robert K. Annett Memorial Award
- Robert Ralph Hammond

The Class of 1951 Frank R. Clegg Memorial Award
- Kristy Lee Gammon

The Carleton C. Whittaker Memorial Scholarship in Psychiatry
- David Harold Douglas Jones

The Leonard Sutcliffe Memorial Scholarship
- Clare Colleen Romano

The John C. Rathbun Memorial Prize in Paediatrics
- Janet Alison Lawrence

The C.C. Ross Memorial Prize in Surgery
- Steven Alexander Martin

The Bristol Prize in Medicine
- Lee Anne Marie Wills

The Lange Awards
- William Alan McCauley
- Robert Alan Beldavs

The Elena B. Wolf Memorial Awards
- Robert John Sales
- Clare Colleen Romano

The Ishiyaku EuroAmerica, Inc./Piccin Nuova Libraria Book Award
- Kathryn Ann Myers

FOURTH YEAR

The Medical Alumni Gold Medal
- Elaine Marie Meinig

The Alpha Kappa Kappa Gold Medal
- David Mark Whiteman

The Dr. R.F. Eccles Scholarship
- Thomas Ross Faulds

The Class of '55 Prize
- Catherine Reid Faulds

The Kingswood Scholarship
- Paul Kevin Keith

The Class of 1917 Prize
- Fred Song Chun Kim

The Rowntree Prizes in Medical History
- Karen Nobuko Watanabe - First
- Jeffrey Allen King - Second

The Dr. Archibald McCausland Memorial Prize in Psychiatry
- Kathleen Anne Ferguson

The R.A.H. Kinch Prize in Community Medicine
- Andrew Malcolm Ballard

The J.B. Campbell Memorial Scholarship in Medicine
- Jane Elizabeth Gloor

The Dr. Fred N. Hagerman Memorial Prize in Surgery
- Gopal Bhatnagar

The Dr. Marvin L. Kwitko Scholarship in Obstetrics & Gynaecology
- Walter Matthew Romano

The Ivan H. Smith Memorial Prize
- Ivar Marcelo Mendez

The Dr. Henri Brealt Award
- Jane Elizabeth Gloor

The Abbott Prize in Anaesthesia
- Timothy James Peter Szozda

The National Council of Jewish Women Award in Obstetrics & Gynaecology
- Corinne Ann Mary Brooymans

The Horner Medal in Ophthalmology
- Sarah Whittlesey Rushforth

The Horner Medal in Otolaryngology
- Kelly Brian Zarnke

The Andrew D. Mason Memorial Award
- Frederick Joseph Lee

The Lange Awards
-Naoki Chiba
- Douglas William Carrie

The Ontario Medical Association Prize in Preventive Medicine
- Walter David Hogarth

The Hewlett-Packard Top Medical Graduate Award
- Coriine Anne Mary Brooymans
- Catherine Reid Faulds
- Thomas Ross Faulds
- Walter Mathew Romano
- David Mark Whiteman

The University of Western Ontario in Cardiology
- Michael Storr

The Radiologists of Western Ontario Award in Diagnostic Radiology
- Cynthia Louise Henderson

The Bill Mood Memorial Award
- Upender Kuman Mehan

The John William Rohrer Memorial Award
- John Anthony Ross

The Robin Middleton Memorial Award
- Jane Elizabeth Gloor

The Dr. Glen S. Wither Memorial Award
- Catherine Reid Faulds

The Roche Scholarship
- Theresa Marcella Koppert

DUCK SCHOOL ...

Internship Trends — Western Students
CIMS Match 1986 and 1987

The following is a summary of the locations 1986 and 1987 graduates of U.W.O. Medical School with a M.D. are completing their internships (PGY-1). The internships presented are rotating unless otherwise stated.

ONTARIO	1986	1987
London		
St. Joseph's Hospital	9	6
University Hospital	1†	2
Victoria Hospital		
-Rotating & General Comprehensive	9	9
U.W.O. Integrated Program		
-Comp. Family Medicine	12	15
-Comp. Medicine	10	8
-Comp. Pediatrics	1	1
-Comp. Surgery	2	3
Total for London	44	44
Toronto		
Mount Sinai - Rotating & Gen. Comp.	1	2
North York Branson	1*	0
North York General	3	5
Scarborough General	1	3
St. Joseph's Health Centre	1	4
St. Michael's Hospital Rot. & Gen. Comp.	4	1
Toronto East General & Orthopedic		
-General Comprehensive	1	0
Toronto General Hospital - Gen. Comp.	3	0
Toronto Western Hospital - Gen. Comp.	1	0
Women's College Hospital	0	1
U of T Integrated Program		
-Comp. Family Medicine	4	6
-Comp. Medicine	3	4
-Comp. Surgery	2	1
Total for Toronto	25	27
Hamilton		
McMaster University Integrated Program		
-Comp. Family Medicine	4	8
-Comp. Medicine	1	3
-Comp. Pediatrics	1	0
-Rotating	0	2
Total for Hamilton	6	13
Kingston		
Queen's Integrated Program		
-Comp. Family Medicine	10	1
-Comp. Medicine	0	2
-Comp. Pediatrics	0	1
-Comp. Surgery	0	1
Total for Kingston	10	5
Ottawa		
Ottawa Civic	3	0
Ottawa General - Comp. Family Med.	1	0
Ottawa General - Comp. Medicine	1	0
Univ. of Ottawa - Rotating	0	4+
Univ. of Ottawa - Comp. Family Med.	0	1
Total for Ottawa	5	5
NEWFOUNDLAND		
St. John's		
Memorial University -Integrated Program		
-Comp. Family Medicine	1	0
-Comp. Medicine	1	0
Total for Newfoundland	2	0

NOVA SCOTIA	1986	1987
Halifax		
Dalhousie University Integrated Program		
-Comp. Family Medicine	1	0
-Rotating	0	2
Total for Nova Scotia	1	2
QUEBEC		
Montreal		
Jewish General Hospital	1	0
McGill University - Comp. Fam. St. Mary Hosp.	0	1
Total for Quebec	1	1
MANITOBA		
Winnipeg		
University of Manitoba		
-Comp. Family Med.	2	0
-Comp. Pediatrics	1	0
Total for Manitoba	3	0
ALBERTA		
Calgary		
Holy Cross Hospital		
-Comp. Family Medicine	1	1
Total for Alberta	1	1
BRITISH COLUMBIA		
New Westminster		
Royal Columbian Hospital	1	2
Vancouver		
St. Paul's Hospital	1	0
Vancouver General - Family Medicine	1	0
Victoria		
Royal Jubilee Hospital	1	0
Total for British Columbia	4	2
(U.S.A.)		
FLORIDA		
Gainesville		
U. of Florida - Comp. Surgery	1	0
Tampa		
Univ. of South Florida - Comp. Med.	0	1
MICHIGAN		
Detroit		
St. John's Hospital	1	0
Total for U.S.A.	2	1
Complete Total Interning	**104**	**101**

(*) Meds'79 graduate
(†) Meds '85 graduate
(+) includes Meds '86 graduate

Continued on Page 12

IN STITCHES

... THEN BOB BEGAN TO WONDER... IF THIS WAS HIS RECTAL THERMOMETER... WHERE HAD HE LEFT HIS PEN?

Continued from Page 11

The past 2 years internship trends for U.W.O. graduates suggest the following conclusions.

1) About 40% of the class interns in London. Rotating internships make up about 1/3 of this group as does Comprehensive Family Medicine. The rest of the group remaining in London are in comprehensive programs that include Medicine, Surgery and Pediatrics.

2) Another 40% of the class interns in one of Toronto, Hamilton, Ottawa and Kingston with Family Medicine and Rotating and General Comprehensive programs being almost equal in preference overall. Of note is a regional disparity in matching with regards to Family Medicine from the 2 years in Hamilton and Kingston. Kingston does not offer a rotating program.

3) There is a small trend over the 1 year for later graduating students to intern in Ontario. 80 of 104 students in 1986 interned in Ontario versus 94 of 101 in 1987. This may reflect a concern by students in licencing requirements for Ontario being better fulfilled in Ontario.

Bob Turliuk
Meds '88

OPINIONS AND REPLIES TO THE EDITOR:

Specifications: - 60 stroke line
- Double spaced
- Type written

Opinions: - 1500 word limit
Replies: - 500 word limit

Send c/o U.W.O. Medical Journal